Exhibit 3

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

FATAL CLAIM PETITION FOR COMPENSATION BY DEPENDENTS OF DECEASED EMPLOYEES

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER [redacted]

DATE OF INJURY 09 - 09 - 2012 (MM DD YYYY)

WCAIS CLAIM NUMBER

EMPLOYEE

First name Adrian L.
Last name Robinson, Jr.
Date of birth 11/21/1989 Date of death 05/17/2015
If deceased - Dependent/Guardian/Personal Representative
First name Adrian L.
Last name Robinson, Sr.
Address 1139 Countryside Drive
Address
City/Town Harrisburg State PA ZIP 17110
County Dauphin Telephone
U.S. Citizen ☑ Yes ☐ No

EMPLOYER

Name Pittsburgh Steelers Sport Inc.
Address 3400 South Water Street
Address
City/Town Pittsburgh State PA ZIP 15203
County Allegheny
Telephone FEIN

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN
Contact
NAIC code or Insurer code
Insurer/TPA claim #

INJURY INFORMATION

Description of injury or illness
Chronic Traumatic Encephalopathy ("CTE")

Check if occupational disease ✓

1. Business of employer Professional football club
2. Time of injury (hour) ☐ a.m. ☐ p.m.
3. The cause of death was Suicide resulting from CTE as given by the Concussion Legacy Foundation at Boston University, Boston, MA
4. The deceased employee incurred the following medical bills (give name of health care provider, address, type of treatment and bill in space below) related to the fatality.
   None
   GIVE NAME AND ADDRESSES. IF NONE, SO STATE.
5. Expenses for the burial amounted to $____.____.
   Amount paid by employer $0.____.
6. The wages of deceased employee at the time of accident were $7500.00 ☐ hour ☐ day ✓ week
7. Notice of injury and/or death was given to employer on 05 - 17 - 2015 (MM DD YYYY) by ____ NAME OF PERSON REPORTING INJURY/DEATH
   in the following manner ____ STATE WHEN AND TO WHOM NOTICE WAS GIVEN AND IN WHAT MANNER
8. Compensation for disability was paid to the deceased from __ - __ - ____ (MM DD YYYY) to __ - __ - ____ (MM DD YYYY)
   Total amount paid was $____.____.

9. Dependents are as follows:

NAME	ADDRESS	DATE OF BIRTH MM-DD-YYYY	RELATIONSHIP	US CITIZEN
Avery Marie Robinson	1916 W. Girard Ave., Philadelphia, PA		Daughter	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

10. Their dependency is ☑ total ☐ partial

11. Petitioner ☐ was ☑ was not living with the deceased employee at the time of his or her death.

12. The petitioner ☐ is ☑ is not a widow/widower of the deceased employee.

a. If petitioner is a widow or widower, state where ceremony was performed and give date of marriage.

b. Was marriage a common law marriage? ☐ Yes ☐ No

13. This is an Act 46 (firefighter cancer) claim

14. Other _____

15. Is there other pending litigation in this case ☐ Yes ☑ No If yes, explain below.

_____

_____

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name Karl J. Januzzi, Esquire

PA Attorney ID number 65575

Firm name Shollenberger Januzzi & Wolfe, LLP

Address 2225 Millennium Way

Address _____

City/Town Enola State PA ZIP 17025

Telephone 717-728-3200

Date of petition 06 - 16 - 2017 (MM - DD - YYYY)

Attorney's signature

Dependent/Guardian/Personal Representative's signature

Adrian L. Robinson, Sr.

Dependent/Guardian/Personal Representative's name (typed/printed)

Notice: This petition must be filled out as fully as possible. The original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. You must serve a copy on all other parties, and on the attorneys of all other parties, if the attorneys are known. A Proof of Service must be attached. A Proof of Service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to the Bureau of Workers' Compensation Claims Information Services.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services	Claims Information Services	Hearing Impaired	Email
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program